ColumbiaDoctors

New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB: ___/___/___

Preferred Phone: _____ Email: _____ Gender: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Patient Marital Status: _____

Primary Care Physician (PCP): _____ PCP Phone: _____

Referring Physician: _____ Referring Phone: _____

Preferred Pharmacy: _____ Pharm Phone: _____

Preferred Pharmacy Address: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:

- □ Decline Response
- □ Hispanic or Latino
- □ Not Hispanic or Latino

Race:

- □ Decline Response
- □ American-Indian or Alaska Native
- □ Asian
- □ Black or African American
- □ Native Hawaiian or Pacific Islander
- □ White
- □ Other

Preferred Language: _____ □ Decline Response

Patient Signature: _____ Date: _____

I understand that charges not covered by my insurance company, as well as applicable copayment and deductible, are my responsibility and are payable immediately upon receipt of patient statement. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient or Guarantor Name (Print): _____

Patient or Guarantor Signature: _____ Date: _____

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

If completed by a patient's personal representative, please print and sign below.

Representative (Print): _____ Relationship: _____

Representative Signature: _____ Date: _____

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General Medical Questionnaire - *Please use back of page if additional space is needed.*

Reason for today's visit: _____

Do you currently smoke? Y N If no, previously? Y N Years smoked _____ Packs/day _____

Do you consume alcohol? Y N If yes, drinks/week _____

Do you have any allergies to medications or other substances? Y N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis). _____

Please list ALL of your current medications, including over the counter medications:

Medication Name	Dose	When do you take it?	Approximate start date

Please list any surgeries you have had and the approximate date. _____

Have you had a blood transfusion? Y N If yes, when? _____

Have you EVER had any of the following?

Asthma/Breathing Problems	Y	N	Heart Disorder	Y	N
Arthritis	Y	N	High Blood Pressure	Y	N
Bleeding/Clotting Disorder	Y	N	Lung Disorder	Y	N
Blood Pressure Disorder	Y	N	Liver Disease	Y	N
Bowel/Stomach Problems	Y	N	Neurological Disorder/Chronic Headaches	Y	N
Cancer	Y	N	Psychiatric Disorder/Illness	Y	N
Cholesterol Disorder	Y	N	Stroke	Y	N
Diabetes	Y	N	Seizure or Epilepsy	Y	N
Eye Disorder (i.e. Glaucoma)	Y	N	Thyroid Disorder	Y	N
Heart Disease	Y	N	Urinary/Kidney Disorder	Y	N

Please list any other medical illnesses or problems and provide details for any of the above conditions.

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
		Y N	
		Y N	
		Y N	
		Y N	